Health Care Innovations Awards- Round Two (HCIA)
Executive Overview

Please complete all fields unless directed otherwise.

Organization Contact Information

Letter of Intent Confirmation Number H-8747BD

Organization Name Rockford Housing Authority

Street Address 223 S. Winnebago St.

City Rockford **State** IL **Zip Code** 61102

Organization TIN 36-2584285 **Organization NPI Number** (if applicable)

Primary Contact Information

First Name Ron **Last Name** Clewer

Bus. Phone 815-489-8750 **Bus. Email** rclewer@rockfordha.org

Primary TIN (if applicable) **NPI Number** (if applicable)

Backup Contact Information

First Name Michelle **Last Name** Cassaro

Bus. Phone 815-489-8750 **Bus. Email** scassaro@rockfordha.org

Organization General Information

Type of Organization Other (Please Specify)

Other Housing Authority

Organization Status Government

Year Established/ Incorporated 1951 (YYYY) **Revenue** $10,001,000-$50,000,000 (Most Recent Fiscal Year)

Project Information

Project Title should reflect the design of your model. Please do not propose a generic-sounding title such as "Health Care Innovation Project". (Max 150 characters)

Project Title	Comprehensive Wellness Solutions

Primary Clinical Condition to be Addressed	Other (Specify)
Other or Additional Conditions or Objectives	Cardiovascular Disease, Coronary Artery Disease, Asthma, COPD, Diabetes

Primary Innovation Category Type	Models to improve health of populations

Additional Innovation Category Type(s)

Please mark an '**X**' next to additional Categories your proposal will address, **excluding** Primary Category above.)

	Models that are designed to rapidly reduce Medicare, Medicaid, and/or CHIP costs in outpatient and/or post-acute settings.
	Models that improve care for populations with specialized needs.
	Models that test approaches for specific types of providers to transform their financial and clinical models.
X	Models that improve the health of populations – defined geographically (health of a community), clinically (health of those with specific diseases), or by socioeconomic class – through activities focused on engaging beneficiaries, prevention (for example, a diabetes prevention program or a hypertension prevention program), wellness, and comprehensive care that extend beyond the clinical service delivery setting.

Priority Areas to be Addressed Within the Innovation Categories

(as referenced in Funding Opportunity Announcement (FOA))

(Please mark an '**X**' next to any areas that apply.)

	Category 1: diagnostic services		Category 1: outpatient radiology
	Category 1: high-cost physician-administered drugs		Category 1: home based services
	Category 1: therapeutic services		Category 1: post-acute services
	Category 2: high-cost pediatric populations		Category 2: children in foster care
	Category 2: children at high risk for dental disease		Category 2: adolescents in crisis
	Category 2: persons with Alzheimer's disease		Category 2: persons living with HIV/AIDS (in particular, efforts to link and retain patients in care and improve medication adherence that lead to viral suppression)

Priority Areas to be Addressed Within the Innovation Categories (as referenced in Funding Opportunity Announcement (FOA)) (Please mark an '**X**' next to any areas that apply.)			
	Category 2: persons requiring long-term support and services		Category 2: persons with serious behavioral health needs
	Category 3: models designed for physician specialties and subspecialties (for example, oncology and cardiology)		Category 3: models designed for pediatric providers who provide services to children with complex medical issues (including but not limited to care for children with multiple medical conditions, behavioral health issues, congenital disease, chronic respiratory disease, and complex social issues)
X	Category 4: models that promote behaviors that reduce risk for chronic disease, including increased physical activity and improved nutrition	**X**	Category 4: models that lead to better prevention and control of cardiovascular disease, hypertension, diabetes, chronic obstructive pulmonary disease, asthma, and HIV/AIDS
X	Category 4: models that prevent falls among older adults	**X**	Category 4: models that promote medication adherence and self-management skills
X	Category 4: broader models that link clinical care with community-based interventions		
	Other Enter text here.		

Project Summaries

Provide a brief summary of the population(s) and their needs that you propose to address in your project. Be sure to include a description of the problem and/or gap in care being addressed, the size of the population, and the opportunities to improve care and/or health and to lower cost. (300 word / 2500char max)

Poverty population s in federally funded public housing. Needs include prevention, early detection, condition management, education and training,case maagement and behaviour change. The target poulation will include a minimumof 1,000 public housing residents. Opportunities are large for early detection, condition management, education, coordinated care, and lifestyle change.

Provide a brief summary of your proposed intervention. Be sure to describe how it will address and/or improve the problem and/or gap in care for the population identified above. Briefly summarize the evidence which suggests your intervention has a likelihood of success.
(300 word / 2500char max)

Project Summaries

Inervention will focus on intensive community wide collaborative and holistic care techologically coordinating social service and medical providers through the local HIE. Cross trained case workers will provide screenings and assessments, early detection, monitoring and education, and condition and all of life care plans. There is a large body of evidence on the efficavy of holistic and collaborative case management as referenced in the narrative.

Provide a brief summary of the improvements you expect from this project, and the measures that will quantify improved health/care and lower costs in the proposed model. Quantify the improvement opportunities and quantify the cost drivers that will be different as the result of the intervention described above. (300 word / 2500char max)

Improvements will be in early detection, condition management, medication review and management, education, and positive lifestyle change. Improvement oportunities have been quantified at a net savings to CMS of $5,392,285 resulting from decreased health care related costs after investments in intensive case management, technology infrastructure, and other program costs per the financial plan.

Provide a brief summary of the proposed payment model that will support your project. Please be sure to address how the model will be sustained. (300 word / 2500char max)

The innovation in Payment model includes pay for performance incentives for case managers based on individual and/or group increase in health status and decrease in care costs. The model will be sustained through shared savings resulting in a projected net over over 77% return on investment to CMS over a 3 year period.

Payment Model Information

All applicants must submit, as part of their application, the design of a payment model that is consistent with the new service delivery model funded by this second round of Health Care Innovation Awards. Alternatively, applicants may choose to submit, as part of their application, a detailed and fully developed payment model as well as a list of payers interested in testing the new payment and service delivery model.

If they have not already done so as part of the application, awardees must deliver, during or by the conclusion of the cooperative agreement period, a detailed and fully developed version of the payment model required above, as well as a list of payers interested in testing the payment and service delivery model.

Does the application include a *detailed* and *fully developed* payment model?	No
If **Yes** above, when will the payment model be ready for launch?	10/14

(Note: While CMS encourages awardees to implement new payment models within the award period,

Payment Model Information

CMS is not obligated to implement payment policy changes during or after the award period.)

Do you currently have commitment / interest from payers (other than Medicare, Medicaid, and CHIP) to participate in the payment model?	No

If **Yes** above**,** please list any payers committed to testing the model in the table below.

Payer Name	**Commitment?**
	Select
Click here to enter text.	Select
Click here to enter text.	Select
Click here to enter text.	Select
Click here to enter text.	Select
Click here to enter text.	Select
Click here to enter text.	Select
Click here to enter text.	Select

Net Savings Projection- for CMS Beneficiaries after Deducting In-Kind Costs (From financial plan)	
Year 1	$42,198
Year 2	$1,784,544
Year 3	$3,565,542
Total	$5,392,285

Partner Organization Information

Please list all Partner Organizations below applying with Applicant

Include any participating payer organizations.

Partner Organization Name	**Partner Organization Type**	**Partner Role**
N/A.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.

Partner Organization Information		
Click here to enter text.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.
Click here to enter text.	Choose an item.	Choose an item.

If more space is needed to add partner organizations, please use the space below to list each organization, organization type, and role.

Ex. Partner Organization Name, Partner Organization Type, Partner Role

Click here to enter text.

Provider Types Involved with Intervention (Please mark an 'X' next to any areas that apply.)				
X	Emergency Medical Technician (EMT)		X	Pharmacist
X	Licensed practical nurse (LPN / LVN)		X	Physician, primary care
X	Non-clinical health workers		X	Registered Nurse
X	NP,PA, and other advance practice RN			Physician, specialist (indicate below)
X	Other	Social service case managers		

Type of Specialty (Please mark an 'X' next to any areas that apply.)			
X	Adolescent Medicine	X	Allergy and Immunology
X	Anesthesiology	X	Cardiology and Vascular Medicine
X	Chiropractic Medicine	X	Dentistry
	Dermatology	X	Emergency Medicine
	Endocrinology	X	Family Practice
X	Gastroenterology	X	General Practice

Provider Types Involved with Intervention (Please mark an 'X' next to any areas that apply.)					
X	Geriatric Medicine			Hematology	
	Hospice and Palliative Care			Infectious Disease Medicine	
	Medical Toxicology			Nephrology	
	Neurology		X	Obstetrics and Gynecology	
X	Oncology		X	Ophthalmology	
X	Optometry		X	Orthopedics	
	Otolaryngology		X	Pain Management	
	Pathology		X	Pediatrics	
X	Physical Medicine and Rehabilitation		X	Podiatry	
X	Preventative Medicine		X	Primary Care, General Practice, and Family Practice	
	Psychiatry		X	Pulmonary Medicine	
	Radiology		X	Rheumatology	
	Sports Medicine		X	Surgery	
X	Urology			Other	Click here to enter text.

Target Population

Target Number of Intervention Sites (If applicable)		Target Number of Participants (Regardless of insurance status)				
			Q1	Q2	Q3	Q4
Year 1		Year 1 (by Quarter)	0	200	300	500
Year 2		Year 2 (Total)	1000			
Year 3		Year 3 (Total)	1000			
Total		Total	3000			

Targeted Number of Participants by Insurance Status (Please provide targets by status for each year)

	Year 1	Year 2	Year 3
Medicaid*	711	711	711
Children's Health Insurance Program (CHIP)*			

Target Population

Medicare Fee for Service or Medicare Unspec.*	66	66	66
Medicare Advantage			
Dually Eligible (Medicare + Medicaid)	223	223	223
Private/Commercial Health Ins./Health Plan			
VA Health System (Veterans of Armed Forces)			
TRICARE (Armed Forces)			
Indian Health Service			
Uninsured			
Other			
Unknown			
**Totals	1000	1000	1000

*Excludes Dually Eligible

** Should match Target Number of Participants in table above

Please describe the source data to be used for Participant Recruitment.
(200 word max)

Rockford Housing Authority internal resident data.

Provide estimated dates for:	**Hiring Project Director** (mm/dd/yy)	**05/01/2014**
	Project Launch (mm/dd/yy)	**07/01/2014**

Claims Data

Please indicate if you will require CMS data, if awarded, during the course of your projects. While CMS cannot make any commitment to provide this data, we are assessing each award's requirements.
For operational purposes please consider alternatives that do not rely on receiving this data.
Medicaid and CHIP data will not be available due to limited availability of this data at CMS.
This is a brief initial assessment only. You will be required to provide more detailed paperwork and data use agreements at a later time including a formal written request from your award lead.

Will you need CMS Medicare FFS data for your project? (Please indicate selection with an '**X**')

X	**Yes**	Please complete Claims Data section, then proceed to Existing Grants Information.
	No	Please proceed to Existing Grants Information section.

What is the reason for the data request? (Please mark an '**X**' next to any areas that apply.)

X	Cost Analysis for Payment Arrangement	**X**	Sustainability Model

X	Patient and/or Risk Segmentation for Intervention	X	Self-Monitoring and Reporting
X	Identification of Patients for Intervention		Other

How soon will data be needed?	Within 1-3 months to establish cost/util baselines
Are patient identifiable data required?	Yes

If you selected **Yes** above, please keep in mind CMS cannot provide identifiable claims data on mental health or substance abuse service for many research grants.
Please explain in the box provided any impact this would have on your project. (max 500 char)

None

Do you have an alternative plan if CMS data cannot be provided?
(Note: Medicaid and CHIP data will **not be available** to due limited availability at CMS.) Yes

If you selected **Yes** above, please describe any impact to the project in lieu of data. (max 500 char)

Can get current data from medical providers, historical would be more difficult to obtain.

Data Collection Capability

Does your proposal involve the provision of services to participants? Yes

If you selected **Yes** above, please indicate if your organization (and partners) have processes and procedures to capture the following information:

Provider Tax IDs	Yes
Practitioner NPIs	Yes
Medicare Participant HICNs	Yes
Medicaid Participant IDs	Yes
CHIP Participant IDs	Yes
Other Payer IDs	Yes
Social Security Numbers (if awardee already collects SSN)	Yes
Participant Name	Yes
Date of Birth of Participants	Yes
Home Address of Participants	Yes
Counts by participant demographic characteristics	Yes
Service Types	Yes

Data Collection Capability	
Dates of Service	Yes

Existing Grant Information

Please describe any grants or other federal contracts that your organization or partner organizations currently receive or will receive during the period of performance which overlap and/or complement this proposal due to staff and/or subject area similarities.
(If more space is needed to add Existing Grants/Contracts, please submit on a supplemental Word document and attach with the application.)

Title of Grant/Contract	Org / Federal Agency Name	Grant/Contract #	Award Amt.	Dates of Award (MM/YY – MM/YY)	Type of Award (CoOp Agreement, Grant, etc.)	Key Staff Overlap?
						Select

Brief Summary of Objectives (Max 500 chars)

Click here to enter text.

Title of Grant/Contract	Org / Federal Agency Name	Grant/Contract #	Award Amt.	Dates of Award (MM/YY – MM/YY)	Type of Award (CoOp Agreement, Grant, etc.)	Key Staff Overlap?
						Select

Brief Summary of Objectives (Max 500 chars)

Click here to enter text.

Title of Grant/Contract	Org / Federal Agency Name	Grant/Contract #	Award Amt.	Dates of Award (MM/YY – MM/YY)	Type of Award (CoOp Agreement, Grant, etc.)	Key Staff Overlap?
						Select

Brief Summary of Objectives (Max 500 chars)

Click here to enter text.

Title of Grant/Contract	Org / Federal Agency Name	Grant/Contract #	Award Amt.	Dates of Award (MM/YY – MM/YY)	Type of Award (CoOp Agreement, Grant, etc.)	Key Staff Overlap?
						Select

Brief Summary of Objectives (Max 500 chars)

Click here to enter text.

Additional Partner/Controlling Interest Information

Please complete the following tables with full and complete information as to the identity of each person or entity with an ownership or control interest in the applicant, including all officers, directors, and partners. If the applicant is a new entity that has been formed by one or more existing entities, please reflect this in the entity table below.

(If more space is needed to add Existing Grants/Contracts, please submit on a supplemental Word document and attach with the application.)

For Persons with ownership or control interests in the applicant:

First Name	**Last Name**	**NPI** (if applicable)	**Address** (City,State,Zip)	**Role**	**% Ownership** (If applicable)

For Entities with ownership or control interests in the applicant:

Legal Name	**NPI** (if applicable)	**Address** (City,State,Zip)	**Relationship**	**% Ownership** (If applicable)

The applicant must report investigations of, and sanctions, penalties, or corrective action plans imposed against, the applicant and any person or entity with an ownership or control interest in the applicant, including all officers, directors, and partners. Please provide information from the previous three year period.

Person / Entity	**Federal or state agency or accrediting body (e.g., DOJ, OIG)**	**Description of infraction**	**Resolution status**

Additional Information

Is your organization or partner organization(s) currently participating in a CMS demonstration model or the Medicare Shared Savings Program?

No

If you selected **Yes** above, please explain below. (max 500 char)

Click here to enter text.

Please describe generally below any financial relationships between or among health care providers and payers and/or patients that may be used in implementing the proposed service delivery and payment models.

Click here to enter text.

Do you anticipate the need for IRB approval from your institution for any aspect of your intervention, including but not limited to collecting patient-identifiable data and providing that data to CMS?

No

If you selected **Yes** above, please explain below. (max 500 char)

Click here to enter text.

If you are a provider organization, does your organization use an Electronic Health Record system?

No

CMS is sometimes requested by others to provide the name of a contact at our applicants. Does your organization desire to be contacted for information on your HCIA project (if awarded) and/or your HCIA proposal (if not awarded) by other organizations?
(Please indicate selection with an '**X**')

X	Yes, OK to share our contact information with other government agencies.
	Yes, OK to share our contact information with other HCIA applicants and awardees.
	No, please do not release our contact information to anyone outside CMS and its contractors for this application (such as evaluators)

Note that CMS may request additional information from you after review of your responses in this Executive Overview and/or in any other submissions you make in connection with your application and proposal.